Coastal Arthritis and Rheumatism Associates, PA.

David D. Fraser, MA, MD, FACP, FACR
Board Certified Internal Medicine
Board Certified Rheumatology

1126B Kellum Loop Rd.
Jacksonville, NC 28546

Phone (910) 577-0177
Fax (910) 577-0183

www.coastalarthritis.com

RHEUMATOLOGY CONSULTATION/REFERRAL

Please complete this form and fax to our office along with pertinent medical records including lab results and x-ray reports, insurance cards, and authorization if needed. We will respond to your request within 48 hours.

REFERRING MD: ________________________ **PHONE#:** __________________

NPI#: ________________________ **FAX#:** _____________________
UPIN#: _______________________ **OFFICE CONTACT:** ____________________

PATIENT'S NAME: ____
SEX: M F DOB: _____________ **SSN:** _______________________________
HOME PHONE: ___________________ **WORK/CELL:** ______________________
ADDRESS: ____
City State Zip
PRIMARY INSURANCE: ______________________ **ID#** ____________________
SECONDARY INSURANCE: ___________________ **ID#** ____________________

AUTHORIZATION REQUIRED? Y N AUTHORIZATION #: ______________

DIAGNOSIS: ____
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Please notify your pt. of the following appointment date and time:

Date: _________________ Time: __________________

Please have patient download new patient paperwork from our website www.coastalarthritis.com . Patient is to fill paperwork out completely and bring to their appointment. If patient is unable to download paperwork they are to arrive for their appointment 45 minutes before their scheduled appointment time.

A map to the office and other new patient instructions available on the website as well.